ATTORNEY OR PARTY WITHOUT ATTORNEY (*Name, State Bar number, and address)*	***FOR COURT USE ONLY***
TELEPHONE NO.: FAX NO. *(Optional):* E-MAIL ADDRESS (*Optional):* ATTORNEY FOR *(Name):*	
SUPERIOR COURT OF CALIFORNIA, ALAMEDA COUNTY STREET ADDRESS: MAILING ADDRESS: CITY AND ZIP CODE: BRANCH NAME	
PETITIONER/PLAINTIFF: RESPONDENT/DEFENDANT: OTHER:	
RECOMMENDATION, CERTIFICATION, AND ORDER FOR MEDICAL, SURGICAL, DENTAL, OR OTHER REMEDIAL CARE	CASE NUMBER:

1. I *(Name):* declare that I am a duly licensed physician or dentist under the laws of the state.
   My telephone number is: ; my fax number is:

2. ☐ I recommend that immunization, medical and dental examination, preventive, therapeutic and remedial medical and dental procedures, and psychiatric or psychological evaluation and treatment be provided to the minor who is the subject of this action as may be deemed necessary or advisable in accordance with sound medical or dental practice.

3. ☐ I recommend that the following ☐ major OR ☐ minor surgical procedure(s) be performed *(specify):*

4. The minor's current condition that necessitates the treatment is *(specify):*

5. The following consequences are to be expected if this treatment is not provided *(specify):*

6. The risks of the treatment are: *(specify):*

Date*:* ▶ _____

☐ PHYSICIAN ☐ DENTIST ☐ OTHER *(specify):*

7. The undersigned ☐ Child Welfare Worker OR ☐ Deputy Probation Officer certifies as follows:
   a. The parents, guardians, and/or caretakers of the minor are:
      ☐ Mother or partner:
      ☐ Father or partner:
      ☐ Guardian:
      ☐ Caretaker:

b. ☐ The whereabouts of the parent, guardian, or caretaker are unknown and the following efforts have been made to locate them *(specify):*

c. ☐ The parent, guardian, or caretaker is incapable of authorizing the treatment for the following reasons *(specify):*

d. ☐ The parent, guardian, or caretaker is unwilling to authorize the treatment for the following reasons *(specify):*

e. ☐ This matter has been set for a hearing on *(specify):*

f. ☐ Notice of the application and hearing, if any, has been given or attempted as follows (attach separate sheet if necessary to describe attempts to provide notice) *(specify):*

e. ☐ Parental rights for the minor were terminated on *(Specify date)*: in action *(Specify case number)*:

Date*:* ▶ _____

☐ CHILD WELFARE WORKER ☐ DEPUTY PROBATION OFFICER ☐ OTHER *(specify):*

QIC: _____ _____

PHONE: _____ _____ _____

Date: ▶ _____

ATTORNEY FOR MINOR

8. The order for medical or dental care and treatment that has been recommended is ☐ GRANTED ☐ DENIED.

9. ☐ It is hereby ordered that the aforementioned physician or dentist is authorized to administer the medical, dental, surgical, or other remedial care for the minor as is described and recommended by the practitioner.

Date: _____

(JUDICIAL OFFICER)